DECEMBER 1952

Mental Hospitals

Volume 3 Number 10

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Veterans Administration Hospital,
Fort Douglas Station,
Salt Lake City, Utah.
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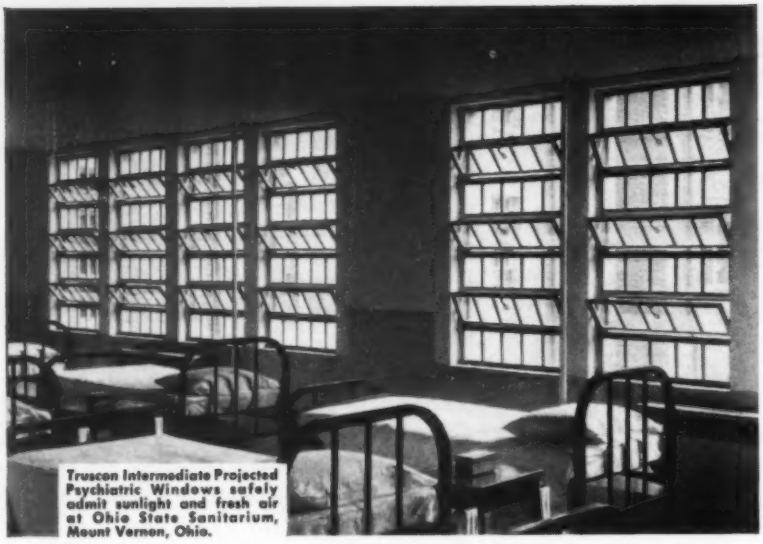

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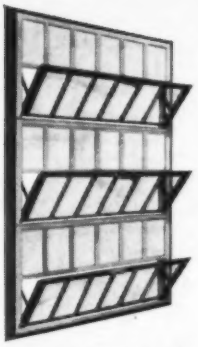

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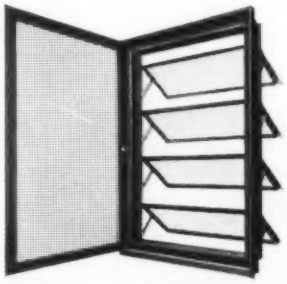

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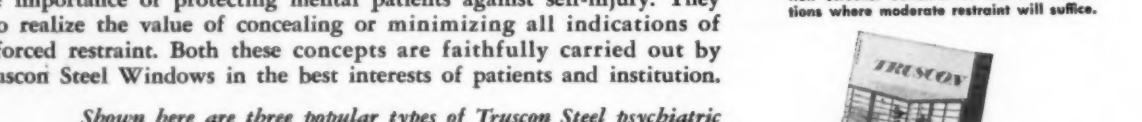

EDITORIAL

The Mental Hospital and the Aging Citizen

Of the many acute problems which the mental hospital has to face, a major one is its responsibility to the aging citizen. There has been a considerable amount of professional and public education in regard to this matter, so there is familiarity with the existence of the problem, although effective solutions have not yet been worked out.

The long-held view that the older the person the less can be done for him therapeutically is quite erroneous, as indeed, are many of our still current beliefs as to the reasons for breakdowns in the elderly. It cannot be stated too categorically that these reasons are not exclusively—and perhaps not even to a major extent—changes in brain structure, in the cardiovascular system or in the systems of elimination. Far more frequently such breakdowns are now recognized as being emotional in nature.

The responsibilities of the mental hospital, therefore, are several: to encourage public education as to the undesirability of a statutory retirement age and to encourage planning for the continued participation of the aging in the work and recreational life of the community; to provide mental health facilities, on a clinical basis, for the aging individual who is growing increasingly puzzled, frustrated, unhappy and disturbed because of adjustment difficulties which are consequent not so much upon his own progressive enfeeblement as upon social customs and beliefs which, with justice, he feels bear unfairly and heavily upon him.

Once the patient has been admitted to the hospital, another series of interesting and provocative problems arises. These stem from the different tempo at which the older patient lives and reacts, and from the limitations imposed upon physical effort and hence, upon mobility. Other problems arise from his difficulty in remembering. Then, too, the accident rates for older persons are high and the hospital administrator must cooperate with the architect to design settings in which the older person can be well cared for.

The general anticipation concerning recovery for the elderly psychiatric patient is far too low. All too often, the apparatus which has been set up for rehabilitation and ultimate discharge is not set in motion for the older psychiatric patient, since it is not expected that he will be able to reestablish himself outside. That fatalism pervades the hospital staff, the family and the community. Experience is proving that it is quite unrealistic. One of the simplest measures to reduce the overcrowding of our mental hospitals is to strengthen therapeutic rehabilitation techniques, in the confident anticipation that we can progressively raise the discharge rate of the older patient.

D. EWEN CAMERON, M.D.,
President, American Psychiatric Association.

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Who Is Responsible For Patient Activities?

By ELIZABETH P. RIDGWAY,

Occupational Therapy Consultant, Dept. of Welfare, Harrisburg, Pa.

ONE OF THE MOST IMPORTANT factors in helping to change insane asylums into psychiatric hospitals has been patient activity. In the old days it was largely a negative matter—a way of keeping patients out of trouble by substituting occupation for restraint. Experience quickly showed, however, that patients under a program of guided activities made real progress. With the advent of psychotherapy and other specific therapies, it became generally recognized that these treatments were successful in proportion to the amount of extra attention the patients received.

This is not the place to discuss rationale but it is very much to the point to indicate that an effective and essential part of "activity treatment" is the opportunity for interpersonal experiences, tempered to meet the needs of the individual patient. Employees responsible for activities, therefore, must be mature individuals, capable of subordinating their personal drives in order to help the patient obtain the sort of life experience he needs for growth.

The increasing demand for activity in psychiatric hospitals has resulted in a bumper crop of specialties. Within the last year the writer had encountered art therapy, bibliotherapy, color therapy, corrective therapy, cosmetic therapy, industrial therapy, dance therapy, drama therapy, educational therapy, ergotherapy, manual arts therapy, music therapy, occupational therapy, recreational therapy, rehabilitation therapy, sports therapy and group work, not to mention physical therapy which sometimes includes active participation.

In this extensive nomenclature there is danger that the word "therapy" will become meaningless. In some instances this is very nearly the case, and unless all such "therapies" become identified with effective treatment under professional supervision, there is increasing danger that all will lose necessary support.

The solution is not in reducing activities. Every one represented on that list can play an important part in the recovery of some patient. Any satisfactory treatment must be predicated on placing that human being, the patient, in his proper situation. He should be the focal point in an institution which is dedicated to helping him find himself. This means, among other things, that he must have access to the types of activities best suited to his personal readjustment.

Everyone who has anything to do with patients shares to some extent the responsibility for maintaining a high therapeutic level of activities. The doctor is expected to assign patients to various programs, to indicate the therapeutic goal of the activity specified and to give any needed guidance or support. The nursing staff is responsible for activities which go on in the ward. In their 24 hour contact with the patient, ward personnel support healthy attitudes and supply valuable information on his current status; they also facilitate assigned activities by making patients available, properly clothed, at the agreed time and place. Ordinarily background knowledge has been supplied by the social worker and the psychologist. Finally, the occupational therapist or other activity worker instructs or supervises the patient in accordance with the doctor's orders, supplemented by his own training and experience.

Thoughtful consideration by the doctor as to the function of an activity for each patient, and his indication of this purpose through prescription, is the core of a good treatment program. Such thoughtful consideration is obviously more productive when the doctor himself is well informed, through team meetings, as to the current responsiveness of the patient. In practice activity becomes more effective in proportion to the expressed interest of the doctor. Many patients consider activities unimportant because they believe that the doctor does not know or care what goes on.

The responsibilities of psychiatric nursing are broad indeed. Good nursing practice places patient welfare ahead of getting walls scrubbed. Ward personnel do not object to the temporary litter of games and magazines or object to having the ward quiet broken by singing. They do not make belittling remarks about the childishness of an activity or display their own lack of interest. These however, are negative virtues. When therapeutic occupations function best, it is found that the nursing department supports and augments the formal program. Nurses and attendants do not merely watch activity—they set the patients an example by participating with enthusiasm, taking the sicker patients as partners. They pass along their observations concerning patient likes and dislikes, not just those concerning hazards. They take time to persuade the uninterested patient, and to hunt out those who hide. When sufficient people are available, they "special" the difficult patient who would otherwise be unable to attend a hospital function. Instead of always keeping the better patients on the ward to do the work, they rotate them and endeavor to develop an interest in both play and work situations in patients unable to go out with regular groups. They do not try to "get everyone off the ward" without due consideration, for they know that the safety of the group and its therapeutic purpose may be jeopardized by too high a ratio of patients to staff or by the inclusion of those whom the group cannot absorb or tolerate. Finally, I take off my hat to those people, be they nurses, technicians, doctors, group therapists, aides or attendants, who encourage patients to initiate suitable activities for their own ward unit, who guide and implement patients' plans where practicable, and who obtain the cooperation of other hospital departments to arrange a picnic or a checkers tournament, to make a garden or to decorate their own ward.

In suggesting that other professional groups also have responsibility for therapeutic activity, I have no intention of underrating the basic responsibility of the occupational therapist, the physical director, the music instructor or the vocational teacher, to use titles current in Pennsylvania. These, the recreational therapist, the education director, and others must take the primary responsibility. They are not responsible for feeding or clothing patients, for shock treatment or diagnosis, for medications or home visits. They can give all their time to the various aspects of treatment through activity, and it is their particular job to meet these patient needs in so far as they can. This means that they should provide work, play, creative expression, mental and physical exercise, and social events in a patient-centered program, adjusted to meet individual requirements. The program must be flexible; not only do patients need change from day to day, but a rigid program soon loses its ability to stimulate patient interest.

As we know, fully trained personnel are in short supply, and we are often obliged to compromise. We are torn between the desire to uphold professional standards which can produce the most effective results, and the terrible needs of thousands of patients who cannot be reached at this level. We need every mature, intelligent person who possesses suitable skills and who can be interested in psychiatric hospital service.

In admitting the need for compromise, however, we must realize that it is of vital importance to reserve the term "therapy" for an activity which is specifically oriented to the emotional needs of patients, and, secondly, that such activities must be directed or supervised by professional people, properly trained and of some experience. It is our hope that education of all professional workers in this field will be standardized at a high level in the near future. Recreational therapists, music therapists and others are working along this line. Occupational therapists are fortunate in already having established standards approved by the Council on Medical Education and Hospitals of the A.M.A. These provide assurance that the currently trained occupational therapist has been exposed to the necessary minimum of medical subjects, therapeutic theory, clinical training and skills, and that the national registration examination has eliminated those who have not come up to standard. This does not mean that all registered occupational therapists are able to function at

a high level with psychiatric patients, but it does mean that current graduates have been automatically screened for professional preparation. Until all occupational therapists are so trained, however, each individual must be evaluated on his individual merits. This is a matter which time will correct.

Until such educational standards are firmly established for all workers within the activities program, those lacking this medical training should be closely supervised by qualified individuals, and should be differentiated by title. Only completely trained professional medical workers should be called therapists.

The philosophy of occupational therapy is to determine the need of the patient, and then to place him in the activity situation which can best fill that need—whether it be creative painting, tearing rags, playing games, digging in the garden or a special group project. The selection of activity is limited only by the skill and ingenuity of the worker, and recreational techniques find their way into the basic occupational therapy shop. Many occupational therapists think of themselves as general practitioners, who work with the patient as a whole, endeavoring to meet his needs but glady referring him to specialists—in music, education or other fields as indicated. Thus, in the small hospital, the occupational therapist can and sometimes does assume responsibility for the complete activity program. He is trained by outlook and philosophy, if not always in skills, for this broad responsibility.

No one person, however, is adequate to supervise all activities in a large hospital. Although it would be ideal if all activities could be co-ordinated into one department, the various activities usually have to be grouped into smaller departments in accordance with the talents of the workers available, and the policies of the particular hospital. Ordinarily one finds from two to five of such departments. If each is headed by a qualified therapist skilled in the technique involved, they should be aware of their single goal, and operate with a minimum of friction.

There are always problems of scheduling activities to avoid gaps, overlapping and competition for patients' time. There are also the correlation of activities (such as music and dance for the production of a show) and the responsibility for the inservice training program for activity personnel, not to mention relations with nursing, social service and other departments, and volunteers. Coordination of program, as outlined, is a demanding, full time job in a large hospital.

In some state hospitals, this responsibility is combined with the duties of assistant superintendent or clinical director, but too much time is involved for this to be completely satisfactory. A well trained therapist, flexible and adept at delegation of responsibility and meeting personnel problems, could accomplish a great deal if given the authority. He would have the advantage of knowing at first-hand all the irritating little problems, and he knows from experience what may be reasonably expected in a given situation. Such a person, capable of integrating a complex program of activities and activity treatments so that the patient gets the maximum benefit is not readily available. However, his selection is a practicable goal, and the existence of such positions may attract people with superior abilities to the field.

As an occupational therapist, I feel acutely the need for an integrated program. It is difficult to maintain the human touch with a "segmented" patient. In summary, therefore, I present the following points:

1) Effective treatment of mental patients calls for a flexible, well rounded, activity program.

2) Optimum therapeutic results can only be obtained by specifically trained people in active cooperation with the whole psychiatric team.

3) Provision should be made for the correlation of complex activity programs by a qualified coordinator, who has the overall responsibility for adjustment of program to meet patient needs.

Social Service

IN-SERVICE REHABILITATION PROVIDES EFFECTIVE RESULTS

A full-time Counselor of Rehabilitation from the State Division of Vocational Rehabilitation is working at the Milledgeville (Ga.) State Hospital, so that the process of returning a patient to employment can be started while he is still confined to the hospital grounds. The results to date indicate that the program is a constructive one and it is developing steadily.

Patients are screened and referred to the Counselor by their ward physician. They are aided to select a vocation and where possible, hospital facilities are used to explore the patients' interests, abilities and aptitudes, or to brush up skills which have become dulled or forgotten. The hospital departments thus used are the beauty shop, the laundry, the hospital ward (for practical nursing), the shoe repair shop, the X-ray department, the dental clinic laboratory and the bakery. Others will shortly be brought into the program, including the plumbing department and the electricians' shop.

When a patient is ready for a furlough he is referred to the vocational rehabilitation counselor in his home county. His training is continued with as little delay as possible. In certain cases where training facilities are not available in the hospital or if he does not wish to return home the patient enters outside training direct from the institution.

Reports so far received indicate that most of these referred individuals are doing well in their efforts to become re-employable; some are in full-time training, some in part time training and others are already placed in a job.

Much has been accomplished during this first year in inter-relating the vocational rehabilitation program with the other hospital departments, to determine how a patient can be most successfully aided in his return to self-support. Although there has been no precedent to show the way, officials of the hospital and of the state division have great hopes of an outstandingly successful program. (5-1)

Equipment & Supplies

REDUCTION IN FILM COSTS WITH PHOTO-ROENTGEN UNIT

The purchase of a Photo-Roentgen Unit, Model 2, Type 2, using 4″x10″ films has effected a large saving for the Veterans Administration Hospital, Bedford, Mass. in their routine annual chest X-ray surveys for patients and employees.

Since 1946 the hospital had been using the 14″x17″ X-ray films for this purpose, and with 1800 patients and 1100 employees, the cost was considerable.

The Photo-Roentgen Unit, which was installed in January of this year, has only been used so far for personnel examinations. From January to June, 1100 were X-rayed at a total expenditure of $110 for film. On the old size film the cost would have been $495, which shows a direct saving of $385 on film alone.

It is now planned to use the unit on patients also and the medical staff believe that at least 50% of the patients can be X-rayed by this method. By making a single exposure of each patient, size 4″x5″, two patients can be done on each 4″x10″ film, which will be a further saving. Moreover the department reports a definite saving of man-hours in the exposure room and in the processing of the films in the dark room. (11-2)

Research

RESEARCH BRIEFS

New York State is setting up a research project at Rockland State Hospital under the newly appointed director of psychiatric research, Dr. Nathan S. Kline. The project is a long term study of many disciplines, each of which has contributed something to the study of mental illnesses. The new project will consider the results of the various studies in common terms in the hope that a common factor, cutting across the lines of existing disciplines, may emerge.

Indiana University has been awarded a grant of $56,900 over a three year period to conduct research in dynamically oriented, brief psychotherapeutic methods for obtaining remission of symptoms in psychosomatic patients. Dr. Philip F. D. Seitz heads the project.

A small study in the Psychiatric Division of the Wayne County (Mich.) General Hospital and Infirmary concerns the effects of coramine on electroshock patients . . . the same hospital is experimenting with group therapy for schizophrenics undergoing electroshock.

THE PATIENT DAY BY DAY

Nursing Service

INCENTIVES NEEDED FOR IN-SERVICE EDUCATION

One of the areas of the Nursing Department in which our need for development is great is that of in-service educational programs for staff nurses. In so many of the hospitals I visit, I hear this plea: "How can I interest staff nurses in educational programs?" or "I have tried different methods and they do not seem to work."

Some of the questions which arise are these: Whose fault is it when the staff nurse is not interested? What incentives have been given to her? Have we as administrators, set an objective for an educational program and have we made a plan?

Our primary interest, of course, is the patient—to give him better nursing care. Some of our objectives, therefore, in an in-service program for staff nurses, must be to provide for their own future professional growth and future promotion, to foster good morale and cooperative working conditions. They must be encouraged to develop eagerness for further knowledge and must become aware of their influence upon the student nurses. Other less obvious objectives are to afford nurses more share in policy-making, and assisting and cooperating with students and attendants. In short, the primary aim of the program should be the development of the individual to the optimum of her capacity. Thus only will the educational program directly benefit the patient through better nursing care.

While the responsibility for the policies of the total educational program rests of course with the Director of Nursing, democratic planning is essential if the program is to attain a high degree of success. Each hospital must first assess the members of its nurse group to find out what specific experiences or preparation each individual has had. It is most effective to discuss the formulation of the educational program with the nursing group once this evaluation has taken place. It is from our accumulated knowledge of their varying backgrounds and consequent needs, and their knowledge of the total educational plan of the hospital, that the interest of the staff nurses will be gained, together with their whole-hearted participation.

The nurses should be included in the total educational plan of the hospital. Some of the most stimulating in-service educational programs have been developed through cooperative planning by the Director of Nursing, the instructors and the staff. Again, it is the Director's opportunity to have the nurses enter into the planning with her, since the program is constructed to stimulate their professional development.

Very often, too, we do not use the educational facilities available in the community. A long time may have elapsed since some of the nurses have graduated. They may need perhaps, encouragement and reorientation in study methods. If there is a college near the hospital, it is often easy to get a member of the faculty to give a series of lectures on education. Using such college facilities not only enables the nurses to take the courses for credit but it also makes for good community relations between hospital and college. There are many courses which could be selected which would enable the nurse to do more effective work.

In regard to topics related to their special field, we should try to give all members of the nursing staff preparation in psychiatry. Some of them will have an affiliation in psychiatry, others will not, so any plan must include a method for providing this. Other lectures planned will be according to the needs of the group and as they progress, should include Ward Administration and Teaching for head nurses.

Concurrently with the program of education, opportunities should be provided for individual members to participate in ward teaching or in other areas where they have something to offer.

An individually planned program such as I have described will arouse and hold the interest of the staff members. It also keeps before the supervisor and others the possibilities of development of various individuals. Such a successful in-service educational program for staff nurses will undoubtedly afford better nursing care for the patient.

ELSIE C. OGILVIE,
A.P.A. NURSING CONSULTANT.

Ancillary Services

ADJUNCTIVE THERAPIES SUBSTITUTE FOR NORMAL ACTIVITIES

From the newly developed hospital manual on Adjunctive Therapies, produced by the Topeka State Hospital (Kans.) for the benefit of its physicians, comes the following:

"In addition to the specific medical procedures which are the basis for psychiatric treatment, psychiatry has drawn also upon those procedures carried out by ancillary medical personnel who have become allied with physicians in hospital practice.

"To the Adjunctive Therapies falls the responsibility for filling the vacuum created by the separation of the patient from his normal activities. . . . Isolated, sporadic or occasional activities in a psychiatric hospital will not meet the needs.

". . . With the patient in the psychiatric hospital the major importance of the specific activity lies in the opportunity it provides for the patient to establish a new kind of relationship with the person guiding the activity and with other persons engaged in the same activity. It is the 'sick' or impaired relationship which must be improved if the patient is to regain his health. . . . The major goal in rehabilitating the psychiatric patient is to reestablish him as a functioning member of a social community. Activities which are not directed toward this goal can lay no claim to being psychiatrically therapeutic.

"This requires that the adjunctive therapists understand the nature of emotional health and emotional illness, the role of interpersonal relationships in health and illness, and the functions of patterns of living in a group setting. They require too that the adjunctive therapists be patient-oriented rather than activity-oriented. Above all, they demand a close and continuous contact between the physician who prescribes and the therapist who carries out the prescription if the physician is to make effective use of the prescribed activity as a therapy.

"Because of the large number of psychiatric patients, the limited number of professional personnel and the narrow range of effective treatment methods, the adjunctive therapies program in a psychiatric hospital is often the only therapeutic endeavor that can reach most patients. . . . a proficient hospital physician must learn to use this tool quickly and skilfully and he must remember that the skill of those who work with him is useless without his guidance and direction."

The manual, which enumerates the various activities in the hospital which the physician may employ, has been placed in Mental Hospital Service Loan Library and may be borrowed for the usual two weeks on receipt of 15¢ in postage stamps to cover cost of postage and handling.

PATIENTS' CLUB RAISES FUNDS THROUGH RE-SALE SHOP

Twice a month at Patton (Calif.) State Hospital a part of the Recreation Building is turned into a department store for several hours in the afternoon. Here groups of patients are brought to make purchases in any of the seven departments. There is a millinery, a men's haberdashery, sections for costume jewelry, special holiday cards, general greeting cards, miscellaneous items, and ladies' ready-to-wear. Each is presided over by two saleswomen, with the exception of the ladies' clothing department. This, being the largest and most popular department, requires three or four clerks.

The merchandise, for the most part second-hand items donated by various local clubs, stores, churches and community agencies, ranges in price from one cent to two and a half dollars. The saleswomen, as well as the two cashiers and bookkeeper, are patients, all members of the hospital's women's club.

Once a week they attend a class on arrangement and upkeep of stock, conducted by the Club's Director, who is a teacher in Department of Adult Education of the San Bernardino City Schools. The club's activities are, in fact, under this Department, as part of a course in Personality Development and Leadership Training.

Profits from the Re-Sale Shop are used to support various Club projects, which include a revolving fund for needy patients leaving the hospital.

A Patient Discusses Overcrowding

One of the State Reports recently received in the offices of Mental Hospital Service contained the following article, written by a mental patient, which is a reminder of what the hospital experience really means to the patient. The article was in the form of an editorial from a monthly patient newspaper.

———

SINCE A MENTAL HOSPITAL in the United States theoretically bears no possible resemblance to the emergency housing set-ups used for refugees at points of arrival in various parts of the world, a sharp word of protest is being made over the crowded wards in these hospitals.

Many of the wards in this hospital allow less than the minimum space planned between beds in order to make room for more beds in a row. In addition to this, some wards take up part of the aisles of the dormitories with beds. One ward is so crowded that the living or day room area has beds in it. Only a few wards can boast the luxury of small bedside stands for the housing of such necessary items as nightclothes, soap, towels, and other toilet articles. To further complicate this arrangement, the hospital enforces a rule forbidding the patient to store any items under his mattress.

Entering the crowded receiving ward the individual experiences the usual feeling of uncertainty which goes with an adjustment to any strange and new environment whether it is a new job, a new town or joining a new organization. In the present day mental hospital this feeling is further intensified by the abruptness of attitude and attention of the 'welcoming committee,' doctors and technicians, who are swamped with the number of patients for which they are expected to be responsible. . . .

Ostensibly people who are mentally ill suffer from greater difficulty in performing the simple functions of daily living; i.e., bathing, dressing, keeping clothes and beds and other personal objects in order, eating, sleeping and rising. Yet these same people are required, upon entering a mental hospital, to adjust to a routine far more complicated than any routine necessary in the normal everyday world outside. While some healthy people dislike even the inconveniences of 'camping out' for a two week vacation as a change from their regular living, understandably enough sick people suffer as much or even more when asked to put up with hospitalization involving from six months to several years time spent in an overcrowded and uncomfortable living environment.

Even that group of patients entering the hospital, well oriented in the outside world but suffering from some personal emotional problem for which they are sincerely seeking guidance, react with normal feelings of resentment, confusion, and uncertainty to the sharp adjustment expected of them in the set-up of the present day mental hospital, which does not yet meet the standards set up by the American Psychiatric Association. Theoretically this group, who because of keener insight have sought treatment before the threatened breakdown occurs, should find the living environment uncomplicated since they aren't in that unfortunate class of patients entering a hospital in the throes of a break-down, unable to think clearly even about simple activities. How chaotic the world must appear to a seriously ill patient viewing his situation from the locked room of a mental hospital.

The simplest request . . . whether it be an aspirin, permission to see a doctor, or to obtain information from a social worker, is loaded with stumbling blocks in the form of the personnel's lack of time to attend to the needs of so many.

Patients frequently are heard joking about the adjustment they try to make to the situation . . . stating that if one is able to learn the complicated routine of living in a mental hospital, they feel one should be able to function adequately anywhere.

Much of the confusion, much of the haste, and much of the misunderstanding existing in both personnel and patients might be alleviated if fewer patients were treated by the existing number of personnel. It is to be hoped that the completion of this hospital's 750 bed treatment center will alleviate present crowded wards and not be used as an excuse to up the present hospital population by 750 more people.

Recreation

FUN THE IMPORTANT ELEMENT OF RECREATIONAL THERAPY

"The recreationalist who is a little sheepish over his slacks and sweater, who dreams of starched white uniforms and a clinical air, has missed the point. Should he feel that his contribution is somehow disreputable because it is not always recorded in the hospital chart, because it is not a nurse's note, a psycho-therapeutic interview, or a laboratory report, he has yet to understand his role.

"The very fact that his work is not narrowly clinical, that it is fun, that it is spontaneous, is the quality that makes it important. He brings the fresh air of the outdoors into the hospital ward. He asks nothing of the patient but that he enjoy himself. Because he is deeply and genuinely concerned with the patient's welfare, he asks that pain yield to the fun of competition, that syringes and scalpels give way for a time to bats and rackets, that despondency bow to the jigging rhythms of a jazz orchestra. Here is relief for the patient from the stare of clinical appraisal, from lips pursed over a thermometer reading, from laden glances and pregnant silence.

"The most careful planning is essential lest play become work, lest spontaneity be dulled by routine and enthusiasm allowed to drift into boredom. The recreational worker needs to create the impression that his visits to the ward or gymnasium are as lacking in serious purpose as the Marx Brothers at the opera; his sudden inspiration for a new game as "zany" as charades at camp.

"He has much against him—the sad fact that some patients, never having learned, simply do not know how to play; the unhappy perversion of ethics which equates all that is fun with all that is sinful; the bumbling sobriety of old Carlyle's spiritual descendants whose intemperate worship of work can never be assailed.

"He can, however, count Nature on his side, with her careless disregard of straight-laced consistency. He can number among his friends those physicians who hold to the belief that the patients are in very fact people. . . ."

DR. PAUL HAUN: "RECREATION IN THE MENTAL HOSPITAL—A PHILOSOPHY", SEPTEMBER JOURNAL OF THE AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION, AND RECREATION.

Public Relations

FOUNDATION FEATURE WRITER FURTHERS PUBLIC EDUCATION

In 1951 the Texas Board of State Hospitals and Special Schools established through the State legislature its Fourteen Point Improvement Plan (See MENTAL HOSPITALS March 1952). After nearly two years of operation more public information as to the operation of this plan seemed to be not only advantageous from the point of view of further public support, but also something to which the taxpayer was entitled.

The Hogg Foundation for Mental Hygiene in the University of Texas agreed therefore to assign a writer to do a series of fourteen articles for syndication through the state newspapers. Each article shows in human terms the result of one of the points. This series, now completed, will begin next January.

The writer tells in simple words about the man who, for lack of attention, spent three years on a state hospital farm, and who, as a result of the follow-up studies initiated by Point 9, is now back in the community and making a good adjustment. Another article tells of the homesickness and fear of the new attendant who had not been properly oriented into the new and potentially alarming world in which she was trying to work. Point 2 of the program calls for proper personnel selection and orientation, a system of job analysis, classification, promotions, and other important personnel policies designed to produce better attendants.

The articles are folksy and admirably adapted to arouse interest and add to the knowledge of the general readers of the Texas newspapers. Copies have been made available to Mental Hospital Service, and will be sent on loan on receipt of 6 cents in postage stamps.

THIS MONTH'S COVER

This Veterans Administration Hospital at Salt Lake City, Utah, the first of its kind to be completed, is a prototype of a series of a new design planned by the VA. This eight-million-dollar hospital has 546 beds located in four buildings and includes ten additional therapy and utility buildings.

The four bed-containing buildings consist of a five-story main building, a TB-NP building, a disturbed building, and an infirm building. The main building houses the general and medical administration departments, the surgical unit, x-ray and dental units, and the principal laboratory. The nursing units in this building are unique in that they are small, ranging from 22 to 30 beds, and consist of single bedrooms, 4-bed, 8-bed, and 16-bed dormitories. Each nursing unit contains a well equipped nursing station overlooking the solarium, a doctor's office, a doctor's examining and treatment room, and a clerk's office. The solaria have three exposures. Detention screens are used throughout so that grills and bars on the windows are unnecessary. The 172 beds in this building comprise the Acute Intensive Treatment Service for psychiatric patients, a 28-bed neurological service, and a 26-bed medical and surgical unit.

The 154-bed TB-NP building is divided into four nursing units. It is virtually a hospital within a hospital, with its own clinical laboratory, dental unit, x-ray unit, occupational therapy shops, patients' library, patients' recreational facilities, and canteen. A complete treatment program for psychiatric patients with tuberculosis is possible.

The infirm building is a one-story, 100-bed building, divided into two nursing units. A feature especially designed for the needs of elderly patients is that of two enclosed courts which are entered from the solaria.

The disturbed and continued treatment building has 120 beds and four nursing units. Facilities for hydrotherapy, occupational therapy, and manual arts therapy are located in the building and an enclosed exercise court is attached to the building.

A large, well designed recreational building provides a 30′ x 60′ swimming pool, a 58′ x 89′ gymnasium, recreation room, bowling alleys, music room, patients' library, and so on. A theater building adjoins and is connected to the recreation building.

Another feature of each nursing unit is a small dining room with round tables seating four persons. The food is prepared in a general kitchen centrally located and moved in heated food carts through underground tunnels to the serving kitchen near to the dining rooms. The general kitchen, the diet kitchen, and the serving areas have their own intercommunication system.

There is a televoice recording system with some 50 stations, distributed in the offices of the professional staff in the four patient buildings. Central recording is in the main building.

The hospital is equipped with a 4-channel radio hook-up, centralized in the recreation building and extending into all patient areas.

The hospital is located across the street from the campus of the University of Utah and, in keeping with the VA policy of building new hospitals in medical centers, this hospital is only a few blocks from the site of the new medical school. This is a Deans Committee hospital and will have training and research programs in conjunction with the University of Utah School of Medicine. Also, because of the close proximity to the University of Utah, plans are underway to develop training programs for clinical psychology and social work.

A. H. FECHNER, M. D.
Manager

Child Psychiatry

NEW CHILDREN'S UNIT OPENS IN MINNESOTA

A 24-bed psychiatric unit for children, opened October 1 at the University of Minnesota Hospitals, is the first facility of its kind in the state. Although there has been out-patient psychiatric service for children since 1938 at the university, cases needing hospitalization had to be cared for in the general pediatric unit or in the adult psychiatric section.

The unit, which was converted from internes' quarters, has provisions for recreation, occupational therapy and other special therapies for children. It is expected to afford more adequate opportunity for the training of undergraduate physicians, nurses and others concerned with pediatrics, and of graduate physicians for specialized work in child psychiatry. The fulltime professional staff hold joint appointments in the departments of pediatrics and psychiatry.

The unit will operate under the department of pediatrics, under the direction of Dr. Irvine McQuarrie. Dr. Reynold A. Jensen is medical director.

The 1951 state legislature granted $115,000 for operating the unit during 1952-53. Of this, $100,000 is to be used for maintenance and supplies. The remaining $15,000 provides for additional teaching staff, medical fellows, psychiatric social workers, occupational therapists, and other personnel.

Geriatrics

AIR TRANSFER OF SENILE PATIENTS

When the new Geriatric Unit at Kerrville, Texas, was opened recently, 250 senile patients were brought in by air, 200 from the Austin State Hospital and 50 from Big Spring State Hospital.

Although many of the patients moved had been classified as somewhat disturbed, only one patient showed any disturbance while in the air. Most of them enjoyed the flight and many who had been more or less out of contact with their surroundings for a long time were obviously interested in the view from the air. Several who had been mute for many months made attempts at coherent speech during the flight. All the patients moved were 65 or over and most were either bedfast or semi-bedfast. Air sickness was minimal, only 12 being slightly affected.

One doctor, one nurse and one attendant travelled with each patient group.

Air transportation was used only after a careful analysis of the physical condition of each patient to be moved, the distances involved, and the costs of transportation.

Austin State Hospital is 105 road miles and 140 rail miles from Kerrville, while Big Spring is 235 miles by highway and 600 by rail. When a final contract was obtained from the airline used, the cost per patient was $19.32 for the Big Spring transfer, and $8.09 from Austin. Travel time was of course much less than by rail or road.

BATHING THE AGED PATIENT

By having one attendant don bathing suit and cap and enter the shower, another standing outside to disrobe the patient and a third to dry him, the new Texas State Geriatric Hospital at Kerrville is able to bathe twenty patients an hour with a minimum of personnel.

Other attendants are freed to give tub baths to patients who would otherwise have had a sponge bath in bed. "Bed-bathing" has now been cut to only 1% of all patients.

With 75 attendants to care for over 500 patients, each patient gets bathed at least three times a week. Soilers are bathed whenever necessary. Skin diseases have been cut down to disappearing point and the wards have lost their "institutional odor."

Problems in the Training of the Psychiatric Aide of Today

By JOHN BLASKO, M.D.,
Formerly Director Professional Education,
Veterans Administration Hospital,
Gulfport, Miss.

MUCH INDEED *has been written about the training of the psychiatric aide, and in this article Dr. Blasko recapitulates some of the findings of his own and many similar programs. MENTAL HOSPITALS is publishing this article mainly for the benefit of the aides themselves, who may have something to add in the way of comment or criticism, or even better, of practical suggestions which would help in training them to assume a professional attitude and capability towards their exacting tasks.*

RECRUITMENT AND SELECTION of good aides is no easy matter, as every hospital superintendent knows. Eloquent appeals, inducements of pay and promotion or the opportunity of doing good have little effect unless the aide can see for himself that his job is worth while, interesting and one which gains the respect of others. Every effort should be made to assist him in recognizing the importance of his place as a member of a complex team, and to encourage him and build up his prestige by utilizing not only educational means but the principle of reward and merit. Recognition should be given for achievement and performance over and above the rating scale.

The dangers of suppressed hostility because of channels of authority and their possible abuse should be kept in mind constantly. No group of employees can work satisfactorily with mental patients where there are frustrations or hostilities. Personnel procedures such as policies concerning leaves, promotions and assignments are important not only from the administrative standpoint but also from the personal standpoint of the individuals concerned.

Selection, training and supervision of the aide are especially important. There is definite evidence that certain personality characteristics will fit one aide for a certain assignment and every effort should be made to get the man and the job together in the beginning. It is sometimes impossible and always difficult to change the job to fit the man, or vice versa. More thought should be given to the desires, aptitudes and personal characteristics of the aide in addition to his experience, training and abilities.

We hear a great deal about the "therapeutic team" but it would appear that we still have not learned how to achieve initiative and individual progress as members of large varying groups having a common goal. Where there are large groups of employees, we frequently find that responsibility is spread too thinly for good leadership. Aides must be helpful, human, sympathetic, friendly, understanding and responsible. Excessive inspecting and double-checking leads to insecurity and inertia on the part of the aide, who is constantly in fear of doing something wrong. Rather than take this chance, he will frequently maintain a very impersonal and aloof attitude in his relationship to patients.

Today's mode seems to be one of assembly line techniques. Everyone has ideas with regard to unification and uniformity. But uniformity in the treatment of mental patients throughout a large hospital will only defeat itself, because there are too many diverse elements.

Of course a good mental hospital does have what is commonly known as "good therapeutic atmosphere." Analyzing this atmosphere, one finds that a good esprit de corps exists in many of the smaller units comprising the total hospital. The basic units in the hospital may be wards, buildings, services, etc. and this esprit de corps is based upon good leadership in the unit, stability of assignments, acceptance by the group and the recognition of common goals in treatment of patients.

This development of a hospital "atmosphere" in which there is freedom of communication and the development of good morale in many small units will be contagious and eventually the whole hospital will show this desirable influence. Good morale is just as contagious as bad morale.

One of the best ways to help the psychiatric aide is a good educational program. Changes will result not from new words but from new techniques and their courageous application. You cannot expect the aide to sit through formal, dry lectures on the properties of oxygen, the modern concepts of schizophrenia and the use of the enema, and absorb very much. Examples and steady guidance rather than precepts and didactic courses are the best techniques for instilling reasoning and understanding in the psychiatric aide.

Short-term didactic courses are not the answer to our problem. Active training programs must be continuous and aimed at helping the aide to understand his own attitude about himself, his job and his coworkers as related to the total problem of treating sick people.

Then there is the question of dealing with injury and accidents to the patient. The usual procedure in many hospitals today is to set up a Board of Inquiry. This Board, in most cases, is only interested in discovering the facts and determining the presence or absence of negligence and the proper disciplinary action. All aides know this and it insures that they keep away from the patient as much as possible. How much better it would be to treat these cases as a spring board for study and guidance and as a part of the general learning process in order to understand what really happened and how it could be prevented in future.

The development of group techniques to instill confidence, trust and acceptance into the aide is long overdue. In these group discussions, the aides would know that their errors of thinking would be acceptable in the group. They would know that there would not be any disparagement of any type of contribution on any level. There would be verbalization by all concerned, no matter how inadequate, of personal experiences; there would be participation in the discussion by which they would gradually approach a higher level of understanding of both themselves and the patient.

The group leader of these discussions could very rarely be successful if he were also the administrator and disciplinarian. This does not mean that administrators or supervisors cannot be good teachers. It means that the very nature of the goal we are seeking makes it impossible for the person who "cracks the whip" to be, at the same time, a trusted friend and advisor. In the job of encouraging aides to learn by experience, the individual who is responsible for assignments, promotions and discipline would have too many handicaps to overcome. The group leader must be able to instill the feeling that there is a bond of sympathy and understanding among the entire group and that the group leader is for them and with them at all times.

A good supervisor is probably the most important person from the standpoint of influence on the training and development of the psychiatric aide. Probably as much has been written on what constitutes a good supervisor as has been written about the atomic bomb. The physical destruction caused by the atomic bomb is in some respects, figuratively, similar to the psychological havoc created by bad supervision.

A supervisor can do and often does the work of any employee that he supervises. Example and steady guidance are very important. A supervisor who only finds fault, checks defects, and makes reports is worse than no supervisor at all. Good supervisors work with the people they supervise and they often work harder, longer and better, which is why they are supervisors.

If the day comes when there are enough well-qualified psychiatric experts to live and work with mental patients day or night, or if some means is discovered which will produce recoveries by alteration of physico-chemico-psychological patterns, then the conventional nursing and aide methods will of course be obsolete. In the light of present day conditions and established knowledge, however, realistic thinking demands that we concentrate on the serious and practical problem of developing the psychiatric aide to his utmost capacity in carrying out his share of the job at hand.

Can Recovered Mental Patients Be Employed in the Psychiatric Hospital?

By THELMA V. OWEN, M.D. &
M. G. STEMMERMAN, M.D.,
Co-Directors, The Owen Clinic,
Huntington, W. Va.

NO ONE DISAGREES with the concept that the job of the psychiatrist is not complete until he is assured the patient is capable of readjusting to productive living. Yet when it is suggested that certain patients can achieve this productive living as mental hospital personnel, the majority opinion is an unqualified "No!"

Why? We, as psychiatrists, should examine and carefully evaluate the whole question and all of its implications. If we cannot recommend the results of our work to ourselves, surely in all conscience we cannot recommend it to others. It is true of course that the personalities of some mental patients are not suited to work with the mentally ill, just as the basic personalities of some "normal" people are not so suited.

It must be borne in mind that we are basing our affirmative opinion on the **recovered** patient, not on all former patients—those in remission or who have merely been returned to their prepsychotic level. By "recovered" we mean the patient who has gained insight into his repressions and basic personality difficulties and has corrected them. This patient is more stable emotionally than he was before his mental break. He is self-confident and thinks clearly and constructively. And, at our hospital, he has had the advantage of an educational program in addition to the psychiatric therapies.

A large proportion of the personnel of our clinic has been recruited from our patients. In selecting a recovered patient to fill a staff vacancy, we use the same criteria that any employer uses in hiring personnel: the person must be qualified for the job, free of any hampering family ties, and have a personality suited to the type of work and to the type of people with whom he will be in close contact.

In our seven and a half years of operation three of our patients have become secretaries in our town office. We are a small hospital (21 beds) and have no social worker, so these secretaries were more helpful than others who were better trained and more experienced in the business world. The most pleasant and efficient secretary cannot develop in a year the understanding of the new patient and his family problems which the recovered patient has gained from her own experience. Frequently the latter can give the patient's family more comfort than the psychiatrist can. In addition, she knows just how far she can help before referring the problem to the psychiatrist. It has been our experience that such a secretary can save the psychiatrist hours of time.

Our occupational therapist had been a successful secretary before admission, but did not find the work satisfying. While hospitalized she decided she would like to become an occupational therapist. After six months hospitalization she attended college in the mornings and worked afternoons at the hospital as an O.T. aide. She then attended occupational therapy school for three years, working at the hospital during the two summers. Following graduation she refused many other job offers in order to return to the Clinic as our O.T.R.

The school which she attended had never before knowingly accepted a former mental patient as a student. The school considered her an outstandingly good student, particularly in psychiatric O.T., so it is likely that she dissipated some of the prejudice against mental illness. During the past two years she has been one of the most popular members we have ever had on our staff. The patients feel she "understands" and they respect her. Also, it gives great encouragement to many patients when they learn that she herself was once a patient.

We had our greatest difficulty in finding a registered nurse. Many nurses applied for the job, but it was evident that they had emotional problems which they thought could be helped by working in a mental hospital. It was difficult for some to understand that this was not a workable idea. One applicant, however, recognized that a nurse with emotional problems should not assume the responsibility of any patients, much less mental ones, and applied to the clinic as a patient. After three months treatment she moved from the hospital to the personnel dormitory. She had the immediate respect of her former fellow patients. She has been with us for a year now. New patients find it difficult to believe that she was once a patient, but say, "Maybe that is why she understands us so well."

A woman who was a patient for four months has been our assistant cook for more than a year. Our new housekeeper has just been discharged to out-patient status after six months' hospitalization. (The patient must be ready for discharge, at least to out-patient status, before becoming a member of the staff.)

Although we have an active musical therapy program (see MENTAL HOSPITALS, January, 1952), we are not large enough to warrant a full-time musical therapist. However, two former patients who are suitably talented and qualified to teach voice and piano respectively, work here part-time. Their success as teachers and therapists is evidenced in the performance, both musical and mental, of their pupils. Undoubtedly it is because they also have experienced mental illness and thus can feel the needs of the patients.

We have not as yet been able to recruit all members of our personnel from patients, particularly aides. In order to instill some understanding of mental illness, however, we insist that all aide trainees be considered as patients for one month before going on duty. They are given a personnel number so that patient statistics will not be confused, but enter as patients and are subject to exactly the same rules. They are given a complete medical examination and psychiatric evaluation; nursing and O.T. progress notes are kept by senior staff members. They live for two weeks on the floor with the sicker patients and then move to the convalescent floor for two weeks.

These aides are naturally not as understanding as if they had actually been ill, but it greatly facilitates training. It also helps the senior staff to have a better understanding of the aides they are training.

We have proven to ourselves and many others that recovered mental patients make very satisfactory personnel. Our policies, as we have described them, may be subject to criticism from many quarters, particularly the more conservative elements. We only know that for us they work, and they work well.

Training

GRADUATE SCHOLARSHIPS AVAILABLE TO NURSES

Two nurses from the St. Peter (Minn.) State Hospital have been awarded two of the 16 scholarships made available by the state for the academic year of 1952-3.

The nurses will attend classes for three months at the University of Minnesota and then spend six months more in the Rochester (Minn.) State Hospital. They will then return to St. Peter as psychiatric nurses and spend some time training aides.

The scholarships provide $125 a month for nine months and are available to nurses who wish to secure certification in psychiatric nursing. The program is expected to increase the number of nurses able to fill positions as instructors and supervisors in state hospitals. The money for the scholarships was provided by the Legislature.

State School Expands to Children's Medical Center

BY CHARLES W. CASTNER, M.D., SUPT., ***Austin State School, Texas.***

IN THE SPRING OF 1952 Dr. George W. Jackson, Medical Director of the Board of Texas State Hospitals and Special Schools and myself discussed the possibility of expanding my school into a complete Children's Medical Center.

This discussion was provoked largely because both of us were frequently called upon to give advice to parents regarding several types of handicapped children—mentally retarded, convulsive, brain injured, cerebral palsied or emotionally disturbed. There was no place to which many of these children could be admitted.

At Austin State School we were—and are—admitting the mentally retarded, but there was urgent need for a facility for the care, training and treatment of other types of handicapped children, some of whom were able to attend ordinary schools.

We are already carrying out some of the planned programs, and hope to expand with the help of the Legislature, our Governing Board and our Citizens' Groups. This article will attempt to show present developments under existing conditions as well as our future plans.

For intensive care, we have set up two units, one for boys and one for girls. In the dining room long wooden tables have been replaced by chrome-legged tables with indestructible, colored composition tops. Only four children sit at each and are served in stainless steel serving trays with vari-colored plastic tableware. Curtains were hung and chrome and plastic upholstered day-room furniture installed. An occupational therapy department, suitably equipped for the children's needs, has been put in, and playground equipment provided in a special play area. We avoid over-crowding to enable staff members to observe each child closely and give him individual attention.

Special Service Teachers give on-the-ward social training, occupational therapy and play therapy to trainable children who cannot attend the academic school.

Some of the text books on cerebral palsy state that their information will not apply if the child is also retarded. Because we could find no other source of information, we had to use our own best judgment. So we designated a one-story building for this group, with a ward for each sex, and a room for physio-therapy. We are now making alterations to make the building more suitable. A trained and experienced staff will be able to improve these doubly handicapped children, and make their lives happier than before.

A large two-story building has been set aside and equipped for the diagnosis and treatment of children suffering from tuberculosis. This is already in operation under the direction of one of our staff physicians.

Included in our plans for future expansion of the proposed medical center are a receiving building and a treatment center for the emotionally disturbed child. The receiving building will be large enough to provide sufficient beds to keep all new admissions in the building, until each child has been examined, observed and tested. The physicians, nurses, psychologists, social workers and technicians in the team would be engaged in this special service and when the child is moved to another part of the school or to another suitable institution, the completed case record will go along with him.

The treatment center for emotionally disturbed children will be on the campus, and, while a separate facility, will be near enough for care in the event of physical illness and for academic school attendance. This center will be staffed by a child psychiatrist, a psychiatric social worker, nurses and technicians. The school now serving our children is an independent district school operating under Texas public school laws, and is accredited through the sixth grade. Thus parents may be assured that if the child is capable of class room work this will be available on the campus. All authorities with whom I have discussed this phase of our plans agree that the more academic schooling the child can have, enough perhaps, to enable him to read simple signs, the better he is likely to succeed vocationally, in the community and even within an institution.

The medical center will also have the advantage of a complete general hospital service, when the State general hospital now being planned is completed. This will make possible the full development of a medical research unit, which will add to the high standards which we hope to establish.

COMMITTEE PREPARING STANDARDS FOR N.P. SERVICES

The A.P.A. Committee on Psychiatric Hospital Standards and Policies is preparing recommendations concerning Standards for Psychiatric Services in General Hospitals. The main emphasis in this report will probably be on services of 50 beds or less, but appropriate reference will be made to larger services such as those in municipal hospitals, psychopathic hospitals, psychiatric institutes, and receiving hospitals. The Committee will welcome recommendations as to the material which should be included. It would also value highly descriptions of problems which have arisen in the plans and construction of such units or in the functional operation of such units. Communications should be addressed to Dr. Jay L. Hoffman, Veterans Administration Hospital, Bedford, Massachusetts, or to the Chairman, Addison M. Duval, M.D., Saint Elizabeths Hospital, Washington 20, D. C.

Legislation

CANADIAN FEDERAL FUNDS FOR MENTAL ILLNESS NEEDS

From Ontario comes news of additional federal funds earmarked to meet the costs of additional equipment for the Toronto Psychiatric Hospital, the Ontario Hospital, Cobourg and for the psychiatric section of the Toronto General Hospital.

At the Toronto Psychiatric Hospital, the outpatient clinic is being enlarged. It is rapidly becoming an important training center for psychiatrists, psychologists, psychiatric nurses and psychiatric social workers. Two additional employees will be taken on and extra equipment purchased.

The Toronto General has allocated its extra funds to special surgical equipment for the new neurosurgical operating room. Patients come here for lobotomies from both the Toronto Psychiatric and the Ontario Hospital, Kingston.

At the hospital in Cobourg, where more than 600 women patients are cared for, money will be spent on extra laboratory equipment, and for equipment needed for the recreational therapy program.

MODEL COMMITMENT LAW REVISED

The National Institute of Mental Health of the Federal Security Agency expects to have the revised edition of "A Draft Act Governing Hospitalization for the Mentally Ill" available for distribution in January. In the two years since the Draft Act was formulated, it has become apparent that certain changes in terminology and text were necessary to implement the original concepts and philosophy of the Act.

Members of the original working committee, representatives of the N.I.M.H., the Office of the General Counsel, Federal Security Agency, and St. Elizabeths Hospital as well as the medical and legal staff of the National Association for Mental Health, took part in the discussions which led to the revision.

Architecture

ARCHITECTURAL CATALOG LIST AVAILABLE FROM M.H.S.

A listing of catalogs covering various architectural specifications and equipment—standards, mechanical and electrical equipment, furnishings, etc.—is available from Mental Hospital Service. The list was prepared by the Office of Technical Services, Division of Hospital Facilities, of the U.S. Public Health Service, and is offered through their courtesy. Please enclose a self-addressed stamped envelope with your request.

COMMENTARY

The October issue of the *American Journal of Mental Deficiency* is devoted to vocational rehabilitation of the mentally retarded. One of the articles, "Employment of the Mentally Retarded," by Anna M. Engel, reports on surveys of the types of employment found by mentally retarded persons and their adjustment to that work. It also explores the factors involved in preparing, counselling and placing the patients. One chart lists a variety of specific jobs possible at different mental levels.

The *Quarterly Journal of Studies on Alcohol* has in its September issue an article outlining current programs on alcoholism being conducted by the various state governments.

How "The Battle of the Work Orders" was won at the V. A. Hospital at Lyons, N. J., is reported in the October *Modern Hospital* by Dr. C. N. Baganz, Manager of the hospital, his assistant, John M. Nichols, and Dr. Paul Weitz, chief of professional services. A new procedure for priority-rating the work orders (requests for maintenance and repair services) was the tactic that won the battle of confusion, conflict and inefficiency resulting from an overload of requests which plagued the maintenance crew of the 2000-bed neuropsychiatric hospital.

Previously, requests sent to various maintenance sections were too often filled in an arbitrary fashion and sometimes disregarded. The problem was solved by having the chief engineer officer accompany the manager and chief of professional services on daily rounds. Thus the need for and feasibility of any repairs requested could be examined on the spot, and work orders from each unit were given priority in accordance with their importance to the total hospital operation. The results, say the authors, have been "most gratifying and almost spectacular."

"The Purchasing Agent Can Help Ease the Labor Shortage" claims Reuben H. Graham in the October *Hospitals*. The answer of course lies in labor-saving equipment, but Mr. Graham points out several angles that should be considered before purchasing any such equipment.

Music Therapy 1951, the proceedings of the National Association for Music Therapy, is a book that every music therapist or music therapy aide will want to have. The book, whose contributors include psychiatrists as well as professional music therapists, is divided into eight sections. These include "Music to Aid the Handicapped Child," "Volunteer Music Service in Hospitals," "Research," "Scope of the Hospital Music Program and Professional Opportunities" (reports from various regions), and a 41-page Bibliography. The book is priced at $3.00 paper bound, $3.50 cloth bound. Orders should be addressed to Esther Goetz Gilliland, Chicago Musical College, 64 East Van Buren Street, Chicago 5, Illinois. The Bibliography is also sold separately for $1.00.

Norwich (Conn.) State Hospital's new laundry is pictured and described by John W. Clarke, the hospital's business manager, in the November issue of the ***"Modern Hospital"***. The plant, which includes a dry cleaning department, cost approximately $750,000, and handles 90,000 pounds of soiled linen in a 40-hour work week.

Lucy Freeman of the New York Times, who is well known to the psychiatric profession, has prepared the latest Public Affairs Pamphlet, entitled ***"It's Your Hospital and Your Life"***. The pamphlet deals with the general hospital's role in the community and Miss Freeman mentions the treatment of emotional illness as a part of that role. She points to Mt. Sinai Hospital in New York as an outstanding example. "There," she says, "liaison psychiatrists accompany the regular medical staff as they make the rounds in the wards, helping patients who ask for aid. They evaluate the emotional components of a patient's illness. In some instances they may save the patient needless operations. . . . Mt. Sinai also has a group of basic psychiatric clinics, . . . and a psychosomatic ward for both outpatients and inpatients."

COMMUNITY HELP NEEDED FOR PATIENT REHABILITATION

The following is an abstract from an article by Dr. John A. P. Millet, and is reprinted from the September issue of the Bulletin of the American Rehabilitation Committee, Inc., 28 East 21st Street, N.Y.C.

". . . The well-trained modern psychiatrist is, as a rule, increasingly optimistic about the future of his specialty. This optimism is well founded. New techniques, both preventive and therapeutic, which have evolved during the first half of this century, have demonstrated clearly that many patients, whose disorders were formerly looked upon as hopeless, can now be restored to partial or complete health when proper skills and proper conditions are made available to them. The economic loss to the community entailed by long periods of hospitalization in the tax-supported state hospitals for the mentally ill could be enormously reduced if a sound over-all program were adopted which made available to every vulnerable person the proper preventive services, and to every sick patient a well-coordinated plan for rehabilitation when convalescence is once established.

". . . Patients suffering from mental and emotional illness are in most instances capable of partial or complete rehabilitation. Such rehabilitation implies partial or complete restoration of adjustment to work, to family, and to the wider social community.

". . . Programs devoted to these ends require the fullest possible use and the best possible integration of existing public and privately conducted agencies.

". . . While a start has already been made in this direction, the increasing burden of mental and emotional illness on individuals, families, and the community, requires that more serious attention be given to the development of new facilities. . .

". . . In view of the overcrowded state of existing psychiatric clinics, community mental hygiene clinics, and state hospitals, thought should be given to the wider use of foster homes and to the establishment in urban centers of intermediate hospitals and rest homes forming a part of, or having close connection with work therapy centers.

". . . Such units could be made available for the convalescent care of patients discharged from general hospitals, but not yet well enough to take their accustomed place in the community, or so disabled as to require a period of continuing care and special training.

". . . Since such a program would involve new buildings and special installations, and would require a staff of resident physicians and of supervising consultants, the cost would be beyond the power of private agencies to support. The salvage of human resources, however, would in the end prove of economic, as well as spiritual advantage to the community as a whole. This fact justifies the hope that our legislators could be brought to give favorable consideration to the establishment of such facilities in two or three of our largest urban centers, where many key agencies are already available, and are struggling to carry loads beyond those for which they are properly equipped, either in personnel or in material resources."

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VOLUME III